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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/21/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Discogram

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes
Psychological evaluation 06/21/12
MRI lumbar spine 02/08/12
Procedure note 03/20/12
Prior reviews 05/31/12 and 07/13/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who has been followed for complaints of chronic low back pain radiating to the left lower extremity. The patient is status post L2-3 and L3-4 laminectomy. Prior electrodiagnostic studies from August 2011 were stated to show a chronic L5 radiculopathy to the right with worsening left L3-4 radiculopathy. MRI of the lumbar spine performed on 02/08/12 revealed disc desiccation and disc space narrowing from L1 to S1. Prior surgical changes consistent with decompression were noted from L2 to L4 and diffuse disc protrusions at these levels were again noted. Foraminal narrowing from L3 to S1 was present secondary to broad based disc protrusions and facet disease. The patient underwent diagnostic epidural steroid injections at left L2 and L3 spinal nerves. Follow up on 05/08/12 indicated that the patient had some improvement in lower extremity symptoms with the diagnostic injections; however, there was no effect on the patient's lower back pain. Clinical evaluation dated 05/22/12 stated that the patient's pain was worse when he walked and improved when he laid down. Physical examination at this visit revealed weakness in the left anterior tibialis left quadriceps and right hip flexors were graded as mild. Reflexes were

reduced but symmetric in the lower extremities and sensation was intact. The patient was recommended for discography to determine pain generators for the patient's chronic low back pain. The patient did undergo a psychological evaluation on 06/21/12 which stated that the patient was good to fair psychological candidate for discography. The request for lumbar discography was denied by utilization review on 05/31/12 due to lack of any psychological evaluations. The request for lumbar discography was again denied by utilization review on 07/13/12 due to lack of support for the requested procedure per current evidence based guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for lumbar discography is not recommended as medically necessary based on the clinical documentation provided for review and guideline recommendations. The clinical documentation provided for review does not indicate at what levels lumbar discography will be performed at. Current evidence based guidelines do not support the use of discography as there are high quality clinical studies which significantly question the efficacy of the procedure in determining pain generators in the lumbar spine. Current evidence based guidelines also indicate that if discography will be used anyway, that the test be limited to a single level testing with one control level. Additionally the clinical documentation provided for review does not establish that the patient has attempted all reasonable methods of determining pain generators in the low back such as facet joint injections or medial branch blocks. No updated imaging to include CT myelogram or electrodiagnostic studies were also provided for review indicating that the patient had exhausted all reasonable attempts at determining pain generators for the patient. As the clinical documentation provided for review does not support exceeding guideline recommendations, which do not recommend discography, medical necessity is not established and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)